Connecticut Department of Social Services
Making a Difference

Testimony before the Human Services Committee
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Good afternoon, Senator Moore, Representative Abercrombie and distinguished members of the Human Services Committee. My name is Roderick Bremby and I am the Commissioner of the Department of Social Services. I am pleased to be before you today to testify on one bill raised on behalf of the Department. In addition, I offer remarks on several other bills on today's agenda that impact the Department.

Bill Raised on Behalf of DSS:

H.B. No. 6973 (RAISED) AN ACT ADOPTING THE UNIFORM INTERSTATE FAMILY SUPPORT ACT OF 2008

This bill adopts the 2008 revisions to the Uniform Interstate Family Support Act (UIFSA), as recommended by the National Conference of Commissioners on Uniform State Laws and required by Public Law 113-183, the Preventing Sex Trafficking and Strengthening Families Act.

Connecticut adopted UIFSA 2001 in Public Act 07-247 effective January 1, 2008. UIFSA 2008 includes provisions to incorporate the Hague Convention on International Recovery of Child Support and Other Forms of Family Maintenance. This multilateral treaty, consented to by the Senate in 2010, provides for the structured exchange of information and consistent enforcement of international cases of child support.

It is important for the Department to note that under Public Law 113-183, verbatim adoption of UIFSA is required as IV-D State Plan requirement to continue to receive federal funding for the IV-D child support enforcement program. Currently, the IV-D child support enforcement program receives 66 percent federal reimbursement for all costs. The cost of the program in FFY 2014 is $79 million, including a federal match of over $52 million. Failure of the state to maintain an approved IV-D State Plan also puts Temporary Assistance for Needy Families (TANF) block grant funds at risk. In FFY 14 funds for the TANF block grant totaled $266.8 million. The state must adopt the act by July 2015 in order to remain compliant with federal requirements.

We ask for your support on this bill.

Other Legislation Impacting the Department:

S.B. No. 271 (COMM) AN ACT CONCERNING MEDICAID REFORM TO PROMOTE AGING IN PLACE

This proposal establishes a pilot program to fund services under the Connecticut Home Care Program for Elders for a specified number of applicants who require a skilled level of nursing care and who are determined to be presumptively eligibility for Medicaid coverage.

The Department appreciates the Committee's dedication to aging in place initiatives and for your ongoing efforts to support and grow such services. At this time the state's Strategic Rebalancing Plan and the Department's long term services and supports waivers currently represent the Department's Medicaid reform agenda and are actively supporting aging in place initiatives.

Connecticut's Strategic Rebalancing Plan establishes the framework for change within the long-term services and supports system of the state. It addresses supply and demand trends for nursing home and community based services, ensuring that the state's investments in services and infrastructure are aligned with the preferences of the people we serve. The plan is guided by the principles of person-centeredness protecting the values of dignity, autonomy and choice for those who seek long-term services and supports.

The Department's long term services and supports waivers, specifically the Connecticut Home Care Program for Elders (CHCP) currently serves 11,500 residents. CHCP focuses on allowing applicants who may be at risk of nursing home placement, to remain at home with the help of home care services. To ensure applicants have prompt access to these services, the Department recently implemented a waiver "hub" with the specific goal of processing waiver applications and renewals in a timely manner. With only three months of active operation, preliminary results indicate increased efficiently in wavier application processing. The Department believes that at this time it would be premature to initiate presumptive eligibility, as this bill suggests, even in a pilot form, without first assessing whether the single waiver hub addresses the timeliness concerns. Additionally, presumptive eligibility, even in a pilot, has the potential to impose significant costs to the Department, as services that applicants are ultimately not eligible for, although received through presumptive eligibility, would not qualify for federal match, and therefore the state would be responsible for 100% of the costs associated.

The Department would also like to note that Medicaid does not fund pilot services, other than through a waiver request. At this time the Governor's proposed budget does not appropriate additional, non-Medicaid dollars to support this proposal.

The Department would, be willing to discuss a study within workable timeframes. The purpose of the study would be to analyze the feasibility of implementing presumptive eligibility in Connecticut in a manner that achieves the objectives of the committee and mitigates the aforementioned risks. However, as written the Department is unable to support this bill.

H.B. No. 6960 (RAISED) AN ACT CONCERNING MEDICAID PRESCRIPTIONS WRITTEN BY HOSPITAL RESIDENT PHYSICIANS AND INTERNS AND THE IMPLEMENTATION OF ELECTRONIC HEALTH RECORD STANDARDS

This bill proposes to adjust the Medicaid claims approval process for services ordered, prescribed or referred by hospital interns and resident physicians. Additionally, the bill also stipulates requirements related to public health reporting measures in relation to the Medicaid Electronic Health Record (EHR) Incentive program.

Before speaking to specific aspects of Section 1 of the bill, the Department believes it is important to explain the background of the concerns that this legislation seeks to remedy, and thereby explain the constraints under which the Department is bound by federal law.

Section 6401 of the federal Affordable Care Act (ACA), as implemented by the federal Centers for Medicare and Medicaid Services (CMS), is a fraud prevention measure that requires that all services ordered, referred or prescribed for Medicaid clients must be ordered, prescribed, or referred by a Medicaid-enrolled provider if the service is to be reimbursed. Specifically, the claims for all such services must include the National Provider Identifier (NPI) of the enrolled ordering, prescribing or referring (OPR) physician or other professional. In other words, if a Medicaid client is seen by an orthopedist who does not participate in Medicaid, all prescriptions, tests, or therapies ordered by that orthopedist cannot be covered and the pharmacies, radiologists, or therapists providing the ordered services cannot be paid. Both the plain language of the federal law and the requirements under CMS's interpretation and guidance, are far more detailed and less flexible than comparable requirements under Medicare.

The Department recognizes the difficulties and confusion generated by this section of the ACA. Working collaboratively with our business partners, providers' professional trade associations, and other stakeholders, we have sought to overcome these difficulties over the past three years. Unfortunately, one area where the Department is still finalizing its approach to compliance with this rule is payment for services ordered by interns and residents in medical training programs. These trainees order most of the services performed in hospitals and write many of the prescriptions in emergency departments. The large majority of residents have already enrolled as Medicaid OPR providers and the Department has been processing thousands of claims for services ordered, prescribed, or referred by those residents. In general, many residents are not licensed, most have NPI numbers, but those who come to Connecticut from foreign countries for their training may not have their NPI when they start their programs, often due to delays in the resident obtaining a social security number. It is this last circumstance that this legislation seeks to address and it is this challenge about which the Department remains in active discussions with the Connecticut Hospital Association.

Section 1 of this bill contains language regarding payment and system operations inconsistent with federal Medicaid requirements that will impair the Department's flexibility to administer

the Medicaid program efficiently. Specifically, Section 1 would require the Department to use comparable claims processing to Medicare ordered by medical interns/residents, even though the federal Medicaid requirements are different (and more stringent) than Medicare.

Recognizing the unique situation of medical residents, the December 2011 CMS guidance specified options in processing claims for services that were ordered or referred by medical interns/residents. These options were discussed extensively with the Connecticut Hospital Association. In an October 2013 meeting with representatives of the hospital association and several hospital residency programs, it was collectively decided to enroll residents individually rather than use the other potential options offered by the CMS guidance. DSS implemented these enrollment procedures accordingly after an extensive system design and implementation process, so that residents have been enrolling individually as OPR providers since July 1, 2014. As of March 1, 2015, 2,422 medical, dental, and podiatric residents have enrolled individually as Medicaid OPR providers. Since that time, thousands of claims have been paid that included a resident's NPI in the ordering, referring or prescribing field.

CMS guidance suggests that states have some flexibility in implementing OPR requirements for services ordered or referred by interns/residents. In particular, CMS suggests that the NPI of Medicaid-enrolled supervising physicians be included on claims where services are ordered or prescribed by unenrolled residents who work under that physician's supervision. In practice, however, this option presents operational challenges, both for the Medicaid program and for hospitals. One inherent challenge is that an intern or resident may be supervised by various physicians at different times and settings and the schedule of supervision may also vary substantially. That variation is an inherent challenge in ensuring that the NPI listed on the claim actually matches the practitioner who ordered or referred the services. Another operational challenge is that only one ordering physician or other prescriber can be identified in HIPAA-compliant claim formats. For example, if an intern/resident prescribes a narcotic, the attending physician must be accepting that his/her name is being used to prescribe these medications, which is also challenging because the attending physician can change frequently for a given resident, creating a substantial likelihood of billing errors and failure to comply with the federal OPR requirement referenced above. Also, if there are questions about the order, the attending physician may not know the circumstances or particulars of why something was ordered if contacted. From a practice point of view, if the actual "prescriber" (i.e., the intern/resident) is not identified individually, emergency questions about prescriptions cannot easily be answered. In addition, as part of the Department's retrospective drug utilization review program, prescribing patterns are monitored and educational letters to prescribers are generated when appropriate. If the attending physician's NPI were listed on the claim rather than the actual ordering intern/resident, then the attending physician would receive this correspondence, when in fact they did not do the actual prescribing.

The Department continues to engage with the hospital association and hospital residency programs to further refine the procedures for enrolling medical residents and appropriately processing claims for services based on an order or referral from a medical resident. That dialogue and further adjustments should be allowed to continue to ensure that the Department can design and implement efficient and effective payment procedures that comply with all

federal Medicaid requirements. Failure to comply with such requirements would put millions of dollars in federal Medicaid reimbursements at risk.

Section 2 of this proposal pertains to requirements for "Meaningful Use" in relation to the Medicaid Electronic Health Record (EHR) Incentive program. Specifically, the provision stipulates requirements related to public health reporting measures. Such requirements currently implicate test transmissions of immunization data to the Department of Public Health and validation of such testing, which must be submitted to the Department of Social Services by physicians and other eligible providers who attest to the pertinent meaningful use measure.

The Medicaid EHR Incentive program, which was authorized by Congress under the American Recovery and Reinvestment Act of 2009 (PL-111-5), seeks to promote the adoption and meaningful use of electronic health record technology. The program provides for payments to individual, "eligible providers" (e.g., physicians, nurse practitioners, dentists) as well as hospitals. Implementing regulations promulgated by CMS govern the specific criteria under which providers may receive incentive payments, including specific meaningful use objective measures pertaining to public health reporting, such as immunization registry reporting. The Department of Social Services reviews and approves providers' "attestations," or applications for meaningful use (MU) payments based on CMS regulations and guidance, including approved state procedures as documented in its Medicaid Health Information Technology Plan, as approved by CMS. Thus, the Department's review includes documentation of public health data transmission pertinent to MU measures.

With respect to the meaningful use of an EHR by practitioners, the EHR system must be able to support transport of information specific to a given practitioner. This holds for reporting of public health as well other MU core and menu objective measures. The intent of the public health objectives is to demonstrate that a provider, including an "eligible professional" (EP) in a group practice or institutional setting, has the full capability to use certified EHR technology to successfully submit data to the public health agency. Thus, the Department is required to validate that the testing documentation can be tied to the individual EP.

The need to validate test results for individual EP's level does not mean that multiple tests are required, however. In fact, as documented in recent CMS guidance, the Meaningful Use Stage 2 federal regulations allow for one test or one single effort to register and onboard all providers in the organization, provided the EP's utilize the same certified EHR technology and share a network for which their organization either has operational control of or license to use (see https://questions.cms.gov/faq.php?faqId=3819). For example, if a large group practice of EP's with multiple physical locations uses the same EHR technology and those locations are connected using a network that the group has either operational control of or license to use, a single test would cover all EPs in that group to meet this objective). Thus, the new language in Section 2 is unnecessary.

The Department of Social Services, Department of Public Health, and Office of Policy and Management have been engaged in discussions with the Connecticut Hospital Association on issues related to public health MU measures and related reporting and documentation requirements. Additionally, DSS, DPH, and OPM have been in conversations with CMS and the

federal Centers for Disease Control and Prevention (CDC), both of which have endorsed DPH's "MUST portal," the testing capability stood up by the DPH to meet MU Stage 1 requirements. Also, CMS and CDC consider this to be a step in the right direction, with the understanding that DPH is supporting and encouraging the use of Public Health Information Network Messaging System (PHIN-MS) as a mechanism to transport immunization data electronically into the Connecticut Immunization Registry and Tracking System, (CIRTS). CIRTS currently is populated using manual data entry and at this time no hospital or practices have submitted data successfully to CIRTS. The Department intends to continue those discussions and hopes to clarify these requirements further, including the fact that while documentation of individual EP test results is required, and multiple tests are not.

For these reasons, the Department must oppose this proposal.